

Chiropractic Care
Dr. Rodney L. Sweet, D.C.

Name _____ Address _____
City _____ State _____ Zip _____ Home phn _____ Cell phn _____
Pager _____ E-mail Home _____ E-mail Work _____
SSN _____ Date of birth _____ Age _____ Height _____ Weight _____
Male Female Single Married Divorced # of children _____ Name of spouse (or parent) _____
Employer _____ Address _____
City _____ State _____ Zip _____ Wk phn _____ Occupation _____

What is the name of your family physician? _____ What city are they located in? _____
Have you ever been to a Chiropractic doctor? _____ If yes, doctor name _____ Date of last visit _____
If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)
1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____
Has this problem been getting worse or staying the same? _____
Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work that may be causing you to experience these complaints _____
Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain: _____
Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of the injury? _____
Do you have an attorney for this work injury? _____ If yes, who is your attorney? _____
Have you been involved in a car accident in the last 12 months? _____ If yes, what is the date of the car accident? _____
Do you have an attorney for this car accident? _____ If yes, who is your attorney? _____
How many other passengers were in the car with you during the car accident? _____
List other doctors consulted for these conditions 1. _____ 2. _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list _____
Please list any current or past injuries and illnesses not listed above _____
Please list all medications (prescription or non-prescription) you are currently taking: Aspirin/Tylenol Pain Killers Muscle Relaxers
 Insulin Tranquillizers Birth Control Pills Others _____

Health Insurance Co. Name _____ Policyholder _____
Name of Spouse's health insurance (if applicable) _____ Policyholder _____
Spouse's Health Insurance Claims address _____ Policy number _____

